CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 370 **Date: NOVEMBER 19, 2004**

CHANGE REQUEST 3572

SUBJECT: New Case-Mix Adjusted End Stage Renal Disease (ESRD) Composite Payment Rates and New Composite Rate Exceptions Window for Pediatric ESRD Facilities

I. SUMMARY OF CHANGES: In accordance with Section 1881(b)(12)(A) of the Act, as added by section 623(d)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), "The Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to individuals at home. The case-mix under the system would be for a limited number of patient characteristics." Use of a case-mix measure permits targeting of greater payments to facilities that treat more costly resource-intensive patients. In summary we are using a limited number of characteristics that do explain variation in reported costs for composite rate services consistent with the legislative requirement. The current composite payment rates will be adjusted for individual patient characteristics and budget neutrality for services furnished on or after April 1, 2005.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/50.1/Outpatient Provider Specific File
R	8/Table of Contents
N	8/20.1/Calculation of Case Mix Adjusted Composite Rate
R	8/50.3/Required Information for In-Facility Claims Paid Under the Composite Rate

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment – Business Requirements

Pub. 100-04	Transmittal: 370	Date: November 19, 2004	Change Request 3572

SUBJECT: New Case-Mix Adjusted End Stage Renal Disease (ESRD) Composite Payment Rates Effective April 1, 2005, and New Composite Rate Exceptions Window for Pediatric ESRD Facilities

I. GENERAL INFORMATION

A. Background: In accordance with Section 1881(b)(12)(A) of the Act, as added by section 623(d)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), "The Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to individuals at home. The case-mix under the system would be for a limited number of patient characteristics." Use of a case-mix measure permits targeting of greater payments to facilities that treat more costly resource-intensive patients. In summary we are using a limited number of characteristics that do explain variation in reported costs for composite rate services consistent with the legislative requirement. The current composite payment rates will be adjusted for individual patient characteristics and budget neutrality for services furnished on or after April 1, 2005.

B. Policy: The methodology for applying patient characteristic adjusters applicable to each treatment will determine the case-mix adjustment that will vary for each patient. Thus, an ESRD facility's average composite payment rate per treatment will depend on its unique (patients) case-mix. The patient characteristic variables that are utilized in determining an individual patient's case-mix adjusted composite payment rate include five age groups, a low body mass index (BMI), a body surface area (BSA), and an adjustment for pediatric patients. Pediatric ESRD patients, defined as under the age of 18, receive a specific case-mix adjustment factor. As a result, none of the other case-mix adjustors, i.e. the five age groups, low BMI and BSA are applicable to pediatric ESRD patients. An ESRD Pricer Program was established to automatically calculate the composite payment rate for a particular patient for a particular month(s). As an example, the ESRD Pricer Program utilizes each patient's height and weight as reported on billing Form CMS-UB 92 to automatically calculate the low BMI and BSA case-mix adjustments to an ESRD facility's composite payment rate.

Budget neutrality is designed to ensure that total aggregate payments from the Medicare Trust Fund do not increase or decrease as a result of changes in the payment methodology. Therefore, the case-mix adjusted composite rate payments for 2004 must result in the same aggregate expenditures for 2005 (as if the adjustments are not made).

While the magnitude of some of the patient specific case-mix adjustment factors appears to be significant, facility variation in the case-mix is limited. Regardless of the type of provider, the average case-mix adjustments for patient characteristics do not vary significantly. This is because of the overall similarity of the distribution of patients among the eight case-mix classification categories across facility classification groups.

Since ESRD facilities can maintain their current exception rates, we expect them to compare their exception rate to their basic case-mix adjusted composite rate to determine the best payment rate for their facility. Each dialysis facility has the option of continuing to be paid at its exception rate or at their basic case-mix adjusted composite rate (which includes all the MMA 623 payment adjustments). If the facility retains its exception rate, it is not subject to any of the adjustments specified in section 623 of the MMA. Determinations as to whether an ESRD facility's exception rate per treatment will exceed its average case-mix adjusted composite rate per treatment are best left to the entities affected.

Each ESRD facility is allowed to notify its fiscal intermediary (in writing) at any time if it wishes to give up or withdraw its exception rate and be subject to the basic case-mix adjusted composite payment rate methodology. The case-mix adjusted composite payment rates will begin 30 days after the intermediary's receipt of the facility's notification letter. ESRD facilities electing to retain their exceptions do not need to notify their intermediaries.

Please note, in accordance with Section 623(b)(1)(D) of MMA, CMS is opening a new pediatric facility exception request window for pediatric facilities that **did not** have an approved exception rate as of October 1, 2004. The statute defines the term "pediatric facility" to mean a renal facility with at least 50 percent of whose patients are individuals under 18 years of age. If a pediatric ESRD facility projects on the basis of prior years cost and utilization trends that it will have an allowable cost per treatment higher than its prospective rate, the facility may request CMS approve an exception to that rate and set a higher prospective payment rate.

CMS will adjudicate these exception requests in accordance with the exception criteria contained in 42 CFR 413.180 and Provider Reimbursement Manual (PRM), Part I, Chapter 27. However, if the facility fails to adequately justify its pediatric exception request in accordance with regulations or program instructions, its exception request will be denied.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3572.1	Fiscal intermediaries (FIs) shall enter a new dialysis rate(s) for April 1, 2005 on FISS Maps 1105, 105A, 105B & 105C.	X								
3572.1.1	FIs shall enter an exception rate in the new entry described in requirement 3572.1 for providers that have an exception rate.	X								
3572.1.2	FIs shall enter zeroes in the new entry described in requirement 3572.1 for providers that have do not have an exception rate.	X								
3572.2	FIs shall populate an OPPS Provider Specific File for each ESRD Facility with the following fields: NPI (Optional), Oscar Provider number, Waiver Indicator, Effective Date, Actual MSA, Actual CBSA, Special Wage Index (Optional) and Special Payment Indicator (Optional), Provider Type (2 new types will be added to the OPPS PSF, e.g., 40, Hospital Based ESRD Facility and 41, Independent ESRD Facility).	X								
3572.2.1	FISS shall adjust any editing appropriately to all allow for provider type 40 (Hospital Based ESRD Facility) and 41 (Independent ESRD Facility).					X				
3572.3	FISS shall pass the following provider data to the ESRD PRICER: Actual MSA, Actual CBSA, Special Wage Index, Special Payment Indicator, Provider Type and the appropriate dialysis rate for the line being priced.					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3572.3.1	FISS shall pass the following Claim Data to the ESRD PRICER: Through Date, Date of Birth, Condition Code 73 Indicator, Condition Code 74 Indicator, Value Code A8 Amount, Value Code A9 Amount, Line Revenue Code.					X				
3572.4	FISS shall install the ESRD PRICER software by April 1, 2005.	X				X				
3572.5	FISS shall send all ESRD claims, with through dates on or after April 1, 2005, to the ESRD PRICER.					X				
3572.5.1	FISS shall use the rate returned by the ESRD PRICER as the "Payment Rate" in the FISS ESRD Pricing Module.					X				
3572.6	FIs shall return to providers (RTP) all 72X Types of Bill (TOBs) not populated with Value Code A8 (weight in kilograms).	X				X				
3572.6.1	FIs shall RTP all 72X TOBs not populated with Value Code A9 (height in centimeters).	X				X				
3572.7	FIs shall instruct renal dialysis facilities (RDFs) to split all ESRD claims using the following criteria: • If Through Date is on or after April 1, 2005 • From Date must also be on or after April 1, 2005	X				X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3572.8	FIs shall inform RDFs that, at any time, the RDF may give up their exception rate by providing written notification to their FI.	X								
3572.8.1	FIs shall notify CMS when a RDF requests a withdrawal of a previously granted exception.	X								
3572.9	FIs shall inform their RDFs that their basic case-mix adjusted composite payment will begin 30 days after receipt of the notification letter.	X								
3572.10	FIs shall instruct RDFs to utilize Condition Code 80 when an ESRD beneficiary receives Home Dialysis in Nursing Facilities (SNF) including Skilled Nursing Facilities.	X								
3572.10.1	FIs shall instruct RDFs to continue to use CC74 when an ESRD beneficiary receives Home Dialysis in Nursing Facilities including SNF.	X								
3572.11	Fiscal intermediaries shall **notify** ESRD providers on or before March 1, 2005, of the opening of a new 180 day window for pediatric facilities to file exception requests.	X								
3572.11.1	Fiscal intermediaries shall verify that a pediatric facility applying for an exception meets the revised definition of a pediatric facility: a renal facility with at least 50 percent of whose patients are individuals under 18 years of age.	X								
3572.11.2	Pediatric facilities shall have 180 days from April 1, 2005 to September 27, 2005, to submit a valid exception request to its fiscal intermediary.	X								
3572.11.3	Pediatric composite rate exception requests received by fiscal intermediaries after their close of business on September 27, 2005, shall be considered untimely and must be denied.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3572.11.4	Fiscal intermediaries **shall not** accept exception applications from any pediatric facility with a current exception rate.	X								
3572.11.5	Delivery of pediatric exception requests to fiscal intermediaries **must** be accomplished through a method which documents the date of receipt. A postmark or other similar date does not serve as documentation of the date of receipt.	X								
3572.11.6	Neither CMS nor fiscal intermediaries shall extend the September 27, 2005 filing deadline.	X								
3572.11.7	Fiscal intermediaries are reminded to be aware of their responsibilities with respect to processing and controlling ESRD exception requests as outlined in §2723 of PRM, Part I.	X								
3572.11.8	Upon receipt of a provider's exception request, fiscal intermediaries should call Ms. Lisa Hubbard at CMS at 410-786-5472.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Pat Barrett (Billing) 410-786-0508; Henry (Gene) Richter (Policy) 410-786-4562 **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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Attachments (3)

ESRD PRICER

Inputs to PRICER

- **Provider File Data**

Field	Format
Actual Geographic Location MSA	X(4)
Actual Geographic Location CBSA	X(5)
Special Wage Index	9(2)V9(4)
Provider Type	X(2)
Special Payment Indicator	X(1)
ESRD Rate from FISS Map 1105 or 105A, B or C	9(7)V9(2)

- **Bill Data**

Claim Items	UB-92	ASC X12N 837i
Through Date	FL 6	2300 | DTP 03
Date of Birth	FL 14	2010CA | DMG02
Condition Code (73 or 74)	FL 24-30	2300 | HI01 - HI12 | BE | C022-02
Value Codes (A8 and A9) / Amounts	FL 39-41	2300 | HI01 - HI12 | BG | C022-02
Revenue Code (082x, 083x, 084x, 085x, 0881 or 0882)	FL 42	2400 | SV201

Factors and Outputs from PRICER

The following factors and outputs are used to determine the final payment rate:

Provider Type	Labor Portion	Non-Labor portion
Wage Index	Drug add-on	Budget Neutrality Factor
Patient Age	Patient Height	Patient Weight
Patient BSA	Patient BMI	BSA factor
BMI factor	Condition Code 73 adjustment (if applicable)	Condition Code 74 adjustment (if applicable)

Fixed Rates and Payment Factors for ESRD Calculation

- Hospital and Independent Facility Specific Rates

	Hospital	Independent
Facility Specific Base Rate	$132.41	$128.35
Labor Portion (wage adjusted)	0.3678	0.4065
Non-Labor Portion (not wage adjusted)	0.6322	0.5935

- Age Adjustment Factors

Age	Multiplier
<18 *	1.62
18-44	1.223
45-59	1.055
60-69	1.000
70-79	1.094
80+	1.174

- Other Factors

Drug add-on	1.087
Budget Neutrality Factor	0.9116
Body Surface Area (per 0.1ΔBSA of 1.84)	1.037
Low BMI (<18.5 kg/m$^{2)}$	1.112
Condition Code 73 (if applicable) **For revenue codes 0821, 0831, and 0851**	Add $20 to final rate
Condition Code 73 (if applicable) **For revenue code 0841**	Add $12 to final rate
Condition Code 74 (if applicable)	Multiply (3/7) by final rate

BSA/BMI Calculation and Factors

BSA = .007184 x (height)^.725 x (weight)^.425

BMI = weight/height(m)^2

Note: The following BSA and BMI factors are not calculated for pediatric patients.

For all patients except those under 18 years of age:
BSA adjustment factor = 1.037^((BSA-1.84)/0.1)

Used only for patients with a BMI less than 18.5:
BMI adjustment factor = 1.112

ESRD Composite Rate: Basic Payment Calculation

1) Wage Adjustments

	Facility Specific Base Rate
X	Labor Portion
	Labor Portion of Base Rate
X	Wage Index
	Wage adjusted Labor Portion
+	Non-Labor Portion of Base Rate → (Facility Specific Base Rate) x (Non-Labor Portion)

Total Wage Adjusted Rate

2) Other Adjustments

	Total Wage Adjusted Rate
X	Drug Add-on Factor
X	Budget Neutrality Factor
X	Age Factor
X	BSA Factor
X	BMI Factor

Total Rate (before any conditional adjustments)

3) Conditional Adjustments

If condition code 73 is present with revenue codes 821, 831, or 851: **(+) $20 to Total Rate**
If condition code 73 is present with revenue code 841: **(+) $12 to Total Rate**
If condition code 74 is present with revenue codes 841 and 851: **(x) 3/7 by Total Rate**

50.1 - Outpatient Provider Specific File

(Rev. 370, Issued: 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

The outpatient provider (OPROV) specific file contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and format are shown below. FIs must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

FIs must also furnish CMS a quarterly file in the same format. **NOTE**: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or blank if alphanumerical.

File Position	Format	Title	Description
1-8	X(8)	National Provider Identifier (NPI)	Alpha-numeric 8 character provider number
9-10	X(2)	NPI Filler	Blank
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CO
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. (Termination date is the date on which the reporting intermediary ceased servicing the provider in question).
49	X	Waiver Indicator	"N" means not waived (under OPPS) and "Y" means waived (not under OPPS).
50-54	9(5)	Intermediary Number	Intermediary #
55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter the appropriate code (must be blank or 00, 02-08, 13-18, 21-23, or 32-38): 00 or blanks = Short Term Facility

			02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 *40 Hospital Based ESRD Facility* *41 Independent ESRD Facility*
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies.
58	X	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank)(blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio.
71-75	9(5)	Bed Size	Indicate the number of adult hospital beds and

			pediatric beds available.
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the facility is physically located.
85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
90-95	9(2) V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless *data element 96* = "1" or "2"
96	X(1)	Special Payment Indicator	Code indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.

The FI enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999.

Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to systems capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

1-4	9(4)	APC Classification - Enter the 4-digit APC classification for which the provider has elected to reduce coinsurance.
5-10	9(4)V9(2)	Reduced Coinsurance Amount - Enter the reduced coinsurance amount elected by the provider

The Shared system will verify that the last position of the record is equal to the number in file positions 97 through 100 multiplied by 10 plus 100 (last position of record = (# in file position 97-100)(10) + 100).

Medicare Claims Processing Manual

Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

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Table of Contents

(Rev. 370, Issued: 11-19-04)

Crosswalk to Source Material

20.1 - Calculation of Case Mix Adjusted Composite Rate

20.1 – Calculation of Case Mix Adjusted Composite Rate

(Rev. 370, Issued: 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

A case mix methodology adjusts the composite payment rate based on a limited number of patient characteristics. Variables for which adjustments will be applied to each facility's composite rate include age, body surface are (BSA), and low body mass index (BMI). These variables are determined in the ESRD PRICER to calculate the final composite rate(including all other adjustments).

The following table contains required claim data required used to calculate a final ESRD composite rate:

Claim Items	***UB-92***	***ASC X12N 837i***
Through Date	*FL 6*	*2300 | DTP 03*
Date of Birth	*FL 14*	*2010CA | DMG02*
Condition Code (73 or 74)	*FL 24-30*	*2300 | HI01 - HI12 | BE | C022-02*
Value Codes (A8 and A9) / Amounts	*FL 39-41*	*2300 | HI01 - HI12 | BG | C022-02*
Revenue Code (082x, 083x, 084x, 085x, 0881 or 0882)	*FL 42*	*2400 | SV201*

The following provider data must also be passed to the ESRD PRICER to make provider-specific calculations that determine the final ESRD composite rate:

Field	***Format***
Actual Geographic Location MSA	*X(4)*
Actual Geographic Location CBSA	*X(5)*
Special Wage Index	*9(2)V9(4)*
Provider Type	*X(2)*
Special Payment Indicator	*X(1)*
ESRD Rate from FISS Map 1105 or 105A, B or C	*9(7)V9(2)*

Based on the claim and provider data shown above, the ESRD PRICER makes adjustments to the facility specific base rate to determine the final composite payment rate. The following factors are used to adjust and make calculations to the final payment rate:

Provider Type	*Labor Portion*	*Non-Labor portion*
Wage Index	*Drug add-on*	*Budget Neutrality Factor*
Patient Age	*Patient Height*	*Patient Weight*
Patient BSA	*Patient BMI*	*BSA factor*
BMI factor	*Condition Code 73 adjustment (if applicable)*	*Condition Code 74 adjustment (if applicable)*

50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate

(Rev. 370, Issued: 11-19-04, Effective: 04-01-05, Implementation: 04-04-05)

Form Locator (FL) 4 - Type of Bill Code Structure

Acceptable codes for Medicare are:

721 - Admit Through Discharge Claim - This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer.

722 - Interim - First Claim - This code is used for the first of an expected series of payment bills for the same course of treatment.

723 - Interim - Continuing Claim - This code is used when a payment bill for the same course of treatment is submitted and further bills are expected to be submitted later.

724 - Interim - Last Claim - This code is used for a payment bill which is the last of a series for this course of treatment. The "Through" date of this bill (FL 6) is the discharge date for this course of treatment.

727 - Replacement of Prior Claim - This code is used when the provider wants to correct (other than late charges) a previously submitted bill. The previously submitted bill needs to be resubmitted in its entirety, changing only the items that need correction. This is the code used for the corrected or "new" bill.

728 - Void/Cancel of a Prior Claim - This code indicates this bill is a cancel-only adjustment of an incorrect bill previously submitted. Cancel-only adjustments should be used only in cases of incorrect provider identification numbers, incorrect HICNs, duplicate payments and some OIG recoveries. For incorrect provider numbers or HICNs, a corrected bill is also submitted using a code 721.
FL 6 - Statement Covers Period (From-Through) - Hospital-based and independent renal dialysis facilities:

Show the dates during which the patient's care was under the supervision of the facility. Exclude dates when the patient's care was under the supervision of another entity (e.g., hospital, another ESRD facility, SNF).

FLs 24, 25, 26, 27, 28, 29 and 30 - Condition Codes

Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

Condition Code Structure (only codes affecting Medicare payment/processing are shown).

02 - Condition is Employment Related - Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.

04 - Patient is HMO Enrollee - Providers enter this code to indicate the patient is a member of an HMO.

59 – Non-Primary ESRD Facility – Providers enter this code to indicate that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility.

73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.

74 – Home – Providers enter this code to indicate the billing is for a patient who received dialysis services at home.

76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

FLs 32, 33, 34 and 35 - Occurrence Codes and Dates
Codes(s) and associated date(s) defining specific events(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code in FLs 39-41, if there is another payer involved.

Fields 32A-35A must be completed before fields 32B-35B are used.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

24 - Date Insurance Denied - Code indicates the date of receipt of a denial of coverage by a higher priority payer.

33 - First Day of Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP - Code indicates the first day of the Medicare coordination period during which Medicare benefits are payable under an EGHP. This is required only for ESRD beneficiaries.

FL 36 - Occurrence Span Code and Dates

Code(s) and associated beginning and ending dates(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

74 - Noncovered Level of Care - This code is used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period.

FL 37 – Internal Control Number (ICN) Document Control Number (DCN) Required for all provider types on adjustment requests. (Bill Type/FL=XX7). All providers requesting an adjustment to a previous processed claim insert the ICN/DCN of the claims to be adjusted. Payer A's ICN/DCN should be shown for line A of FL 37.

FLs 39, 40, and 41 - Value Codes and Amounts

Code(s) and related dollar amount(s) identify monetary data that are necessary for the processing of this claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed, except in FL 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, show the codes in ascending alphanumeric sequence. There are four lines of data, line "A "through line "B." FLs 39A through 41A are used before FLs 39B through 41B (i.e., the first line is used up before the second line is used and so on).

Value Code Structure (Only codes used to bill Medicare are shown.):

06 - Medicare Blood Deductible - Code indicates the amount the patient paid for un-replaced deductible blood.

13 - ESRD Beneficiary in the 30- Month Coordination Period With an EGHP - Code indicates that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim.

37 - Pints of Blood Furnished - Code indicates the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible. Hospital-based and independent renal facilities must complete this item.

38 - Blood Deductible Pints - Code indicates the number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. Hospital-based and independent renal facilities must complete this item.

39 - Pints of Blood Replaced - Code indicates the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for un-replaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039x revenue code series, Blood Administration. Hospital-based and independent renal facilities must complete this item.

44 - Amount Provider Agreed To Accept From Primary Payer When This Amount is Less Than Charges But Higher than Payment Received - Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.

47 - Any Liability Insurance - Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

48 - Hemoglobin Reading - Code indicates the hemoglobin reading taken before the last administration of Erythropoietin (EPO) during this billing cycle. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit.

49 - Hematocrit Reading - Code indicates the hematocrit reading taken before the last administration of EPO during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

67 - Peritoneal Dialysis - The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report amount in whole units right-justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)

68 - Erythropoietin Units - Code indicates the number of units of administered EPO relating to the billing period and reported in whole units to the left of the dollar/cents delimiter. NOTE: The total amount of EPO injected during the billing period is reported. If there were 12 doses injected, the sum of the units administered for the 12 doses is reported as the value to the left of the dollar/cents delimiter.

71 - Funding of ESRD Networks - Code indicates the amount of Medicare payment reduction to help fund the ESRD networks. This amount is calculated by the FI and forwarded to CWF. (See §120 for discussion of ESRD networks).

A8 – Weight of Patient – Code indicates the weight of the patient in kilograms. This amount is utilized to calculate body mass index (BMI). The weight of the patient should be measured during the last dialysis session of the month.

A9 – Height of Patient – Code indicates the height of the patient in centimeters. This amount is utilized to calculate BMI. The height of the patient should be measured during the last dialysis session of the month.

FL 42 - Revenue Codes

The revenue code for the appropriate treatment modality under the composite rate is billed (e.g., 0821 for hemodialysis). Services included in the composite rate and related charges must not be shown on the bill separately. Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

082X - Hemodialysis - Outpatient or Home Dialysis - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

0 - General Classification	HEMO/OP OR HOME

1 - Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

083X - Peritoneal Dialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by instilling a special solution into the abdomen using the peritoneal membrane as a filter.

0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 -Other Peritoneal Dialysis	PERTNL/HOME/OTHER

084X - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance 100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 -Other CAPD Dialysis	CAPD/HOME/OTHER

085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient. - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 -Other CCPD Dialysis	CCPD/HOME/OTHER

FL 44 - HCPCS/Rates

When a revenue code in the 083x series (peritoneal dialysis) is placed in FL 42, an entry must also appear in FL 44. This entry identifies the duration (number of hours) of the peritoneal treatments. Peritoneal dialysis is usually done in sessions of 10-24 hours duration 7 days a week, and each session is billed and paid as one treatment. Providers enter the number of hours for each session in Value Code 67. They also enter the number of sessions (treatments) in FL 46.

Peritoneal dialysis sessions of between 20-29 hours duration is paid as 1 1/2 treatments. However, for purposes of billing, fractions or decimals are not acceptable. The number of treatments is rounded upwards, e.g., 1 1/2 treatments are equal to 2. The total number of treatments is placed in FL 46. The number of hours for each treatment is entered in FL 44 so that proper payment may be made.

Extended peritoneal dialysis sessions of 30 hours or more, given once a week, in place of 2 or 3 sessions of shorter duration are billed and paid as three treatments. Providers enter the number of hours for each session in FL 44. They also enter the number of treatments in FL 46.

Modifiers are required for ESRD Billing for Adequacy of Hemodialysis. ESRD facilities should report information about the range of urea reduction ratio (URR) values through the use of a G modifier attached to the CPT code 90999 in FL 44 of the UB-92. The CPT code and modifier are required for dialysis reported through UB-92 revenue codes 0820, 0821, and 0829.

G1	Most recent URR of less than 60%
G2	Most recent URR of 60% to 64%
G3	Most recent URR of 65% to 69.9%
G4	Most recent URR of 70% to 74.9%
G5	Most recent URR of 75% or greater
G6	ERSD patient for whom less than seven dialysis sessions have been provided in a month

FL 46 - Units of Service

Hospital-based and independent renal facilities must complete this item. The entries quantify services by revenue category, e.g., number of dialysis treatments. Units are defined as follows:

0634 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of less than 10,000 units of EPO was administered.

0635 - Erythropoietin (EPO) - Administrations, i.e., the number of times an injection of 10,000 units or more of EPO was administered.

082X - (Hemodialysis) - Sessions

083X - (Peritoneal) - Sessions

084X - (CAPD) - Days covered by the bill

085X - (CCPD) - Days covered by the bill

FL 47 - Total Charges

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities show their customary charges that correspond to the appropriate revenue code in FL 42. They must not enter their composite or the EPO rate as their charge. Independent facilities may enter their composite and/or EPO rates.

Neither revenue codes nor charges for services included in the composite rate may be billed separately (see §90.3 for a description). Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

The last revenue code entered in FL 42 as 000l represents the total of all charges billed.